The NHS: a liberal blueprint

Norman Lamb
ABOUT THE AUTHOR

Norman Lamb

Norman was elected as MP for North Norfolk in 2001. In 2003 he was elected to the Treasury Select Committee. Since December 2006, Norman has served as the Liberal Democrat shadow health secretary.
Contents

Introduction 4
A shift from bureaucratic control 10
A new approach to financing the NHS 18
Returning autonomy to NHS staff 33
Patients with rights and responsibilities 38
Conclusion 44
Introduction

The National Health Service (NHS) faces a perilous period ahead. After years of significant real terms increases in funding, spending is set to dry up over the coming years. Last summer, the King’s Fund and the Institute for Fiscal Studies published a report which identified the need for substantial improvements in productivity within the NHS to meet the health needs of the nation, given the anticipated freeze on budgets.¹ They concluded that between 2011/12 and 2016/17, the NHS would have to make productivity gains of between £23.5 billion (£3.9 billion per year) and £48.9 billion (£8.2 billion per year) simply to maintain services at current levels. Given the recent record of declining NHS productivity this is a monumental task.

These are the conditions for a perfect storm: rising healthcare costs due to the ageing of the population and the growth of chronic diseases, combined with no increases in funding. Without reform to secure more efficient use of the available resources, the consequences could be disastrous. The last time the NHS faced a financial squeeze – in 2005/06 – recovery was driven by crisis management. The result was that all the wrong things were cut, such as public health programmes and mental health services, hitting some of the most vulnerable people the hardest. Now, the financial challenge is far greater.

Those of us who believe in the core principle of the NHS – the availability of free care for all – have to demonstrate that, in an age of austerity, the NHS can survive and that patient

care can still be improved to rival the best in the world. If we fail, then the clamour of those who do not believe in the NHS will grow ever louder, and public support for this remarkable institution will be undermined. Its very existence would then be in jeopardy.

60 years ago, that great liberal, William Beveridge, had the vision to establish the NHS. Now we need a new liberal blueprint for an efficient, responsive, high quality NHS, fit for the 21st century.

This paper sets out the principles which should shape a modern, sustainable health service. First, however, it assesses the current state of the NHS and recent trends in health spending.

HEALTH SPENDING IN CONTEXT

The cost of health care in all developed countries has risen inexorably over the last few decades. The UK is no different. As a percentage of GDP, total spending on the NHS has increased from 4.1 per cent in 1970 to 7.3 per cent in 2007.²

The growth of spending has been uneven. While spending in real terms has rarely fallen, the rate of increase has followed a volatile path of feast and famine driven by political imperatives – hardly the best way to guarantee good quality health services.

Between 1970 and the late 1990s, public spending on health in the UK went from above, to well below, the average for G7 countries.³ By the time the Conservatives left office in 1997, the UK was spending 14 per cent less per capita on health compared to the average for the rest of the EU.

The consequences were there for all to see: long waiting times, poor cancer and stroke survival rates, inadequate investment in hospitals and clinics, and insufficient numbers of doctors and nurses.

² Office of Health Economics, using Treasury figures.
On a number of key indicators, the NHS has not performed well by international comparison. Over the last decade, as real terms investment in the NHS increased by a third, the picture has improved. However, three key points emerge:

- The improvements in outcomes have not been as great or as fast as one might have hoped given the scale of increased investment
- From 1997 to 2007 productivity actually fell.4
- Health inequalities have increased

As things stand now, total spending on healthcare in the UK still lags behind most of the major world economies, although the gap has narrowed. It is worth noting that public spending makes up a higher proportion of total spending on healthcare

---

in the UK compared to most other countries.\(^5\)

The scope for greater efficiency is clearly there. Professor Nick Bosanquet of Imperial College, who is an adviser to the Health Select Committee, estimates that the potential scope for efficiency gains is up to 10 per cent of the total spend on the NHS – that equates to over £10 billion.\(^6\) Derek Wanless, in his 2002 report to the government on NHS funding, outlined a range of scenarios for future NHS spending.\(^7\) The best scenario, which he described as “fully engaged”, involved the most efficient use of resources. However, when Wanless reassessed the NHS in 2007, he concluded that it: “Had failed to generate the relatively modest improvements in unit cost productivity that might have been expected and were assumed by the 2002 review.”\(^8\)

This view was echoed a year later by the Audit Commission, which warned that the government’s reforms “had little direct

\(^6\) In conversation with the author.
\(^7\) D Wanless, ‘Securing our future health: taking a long-term view’, 2002.
impact on efficiency”. Likewise, the King’s Fund found that the government’s 2009/10 ‘Operating Framework’ for the NHS was “weak” on suggestions as to how to improve efficiency.  

There is now a widespread consensus that many of the extra resources have been squandered. Labour has presided over a highly centralised, bureaucratic system. The NHS has been over-burdened with managers, complex regulation, perpetual organisational change, top-down, politically driven initiatives and pay deals which have run massively over budget.

The result is an inefficient, largely unreformed system which faces intolerable strain as cost pressures continue to grow. A new approach is needed if the NHS is to survive and deliver the best quality of care.

THE GUIDING PRINCIPLES AND AIMS OF REFORM

Liberal reform should be guided by the following organising principles:

1. A fundamental shift away from central bureaucratic control to local accountability and responsibility.

2. Better use of financial levers to achieve key policy objectives – better quality care, a more efficient use of resources, more support for those with chronic long term conditions, and a greater focus on the promotion of health and well-being.

3. No state monopoly of provision. The test should always be the quality of care irrespective of who provides it.

4. More freedom, thereby liberating the NHS workforce which has been suppressed by a top-down culture which too often fails to get the best out of staff.

5. Giving power and responsibility to patients with respect to their own healthcare.

---


The aim throughout is to move away from centralised control by radically rebalancing the relationship between the politicians, clinicians, patients and local communities.

Fortunately, there is a good deal of evidence emerging from local initiatives and innovations, both in the UK and abroad, to guide this process. These show how patients can be empowered, staff can be engaged, and both efficiency and the quality of patient care can be improved through the use of new working practices. What is striking, however, is the way in which these initiatives have happened despite the present system, not because of it.
1. A shift from bureaucratic control

The NHS is so vast that many believe it is impossible to achieve greater efficiency without a fundamental shift away from the current system of centralised bureaucracy.

The Government’s rhetoric has all been about decentralising power, but in reality Whitehall’s control remains largely intact. Real decentralisation of power involves a transfer of political accountability and responsibility. However, the commissioning of healthcare locally is in the hands of Primary Care Trusts (PCTs) whose boards are appointed nationally with no local input.

This needs to change. The commissioning of local health services should be democratically accountable. Boards of PCTs – which should be renamed local health boards – should be elected, not appointed, so that they can be held to account at a local level. Local health boards would be under a statutory duty to secure quality and value for money for local people. They would be obliged to test the quality of care and value for money offered by providers whether in the public, private or third sector.

There is a growing recognition that you cannot deliver the best quality care or optimise efficiency with a state monopoly. The scandals of Maidstone, Mid Staffordshire and Basildon, as well as the horrifying death toll from hospital acquired infections, demonstrate that totally unacceptable standards of care can and do occur in the state sector, just as elsewhere. Providers, whether in the public, private or voluntary sector, should be judged on the quality of the care they provide. The local health board’s task is to act as a guarantor of quality
care for local people irrespective of who provides the service. A mixed health economy with competition between providers and real choice for patients can drive up standards and achieve a much more efficient use of resources.

Once elected health boards are established, the next stage would be to decentralise the power to raise a proportion of total revenue to fund local health services. Ultimately local health boards should have financial as well as political responsibility and accountability. This would establish an additional incentive to use resources efficiently.

In a decentralised model, the need for a costly, all-powerful Department of Health, micromanaging the day-to-day operation of the NHS, disappears. Reducing the size of the central bureaucracy could lead to enormous efficiency savings. The next step must be to commission a study to determine the necessary scale and function of a core central department in a genuinely decentralised NHS.

The Labour government has created a complex web of quangos and regulators, employing over 25,000 people and costing over £1.2 billion. The regulation and inspection of hospitals is often duplicated with over 60 organisations asking different questions, applying different standards and reaching sometimes different conclusions. The consequence is that every hospital now needs an army of clerks simply to respond to regulatory requirements, often with no clinical engagement. A tick box culture has been created which prioritises ‘paper safety’ over the safety of real life patients.

There is an extraordinary overlap of functions on a national scale. For example, several national organisations, each with its own reporting requirements, have some responsibility for patient safety.

There should be a single organisation with responsibility for keeping patients safe. Furthermore, there should be no more

---

11 Author’s calculation from annual reports.
than one national organisation asking a hospital any one question. If information really is needed by more than one organisation then it should be shared. To rationalise and simplify the system, the following quangos should be abolished:

**National Patient Safety Agency:** its functions can be subsumed within the Care Quality Commission.

**The Independent Reconfiguration Panel:** this panel considers referrals from Overview and Scrutiny Committees relating to significant changes or reconfigurations in NHS services and advises the Secretary of State. In a decentralised NHS, such decisions would be made locally, by democratically accountable bodies.

**National Treatment Agency:** this is the funding mechanism for drug treatment – but not alcohol treatment services. Drug and alcohol treatment should be dealt with in the same way – through local commissioners.

**Connecting for Health:** this agency within the Department of Health, responsible for implementing the National Programme for IT, should also be scrapped as we move away from a centrally imposed IT system (see page 13).

Further, the **NHS Appointments Commission** could be substantially slimmed down as it would no longer be required to appoint to boards of primary care trusts or strategic health authorities.

**The NHS Litigation Authority** should only deal with litigation. At present, one of its key functions is what the Framework Document calls ‘risk management’. Yet the NHS Confederation, in its analysis of regulation ‘What’s it all for?’ found that the Authority’s responsibilities overlap those of the Care Quality Commission which should bear all the responsibility for risk management. This would cut out some of the duplication of enquiry and inspection which hospitals suffer.

There should also be a review of the remuneration of the chairs and chief executives of quangos. Salaries have grown enormously between 2005 and 2008. 19 out of the 23 chief executives of NHS quangos earn six figure salaries, with many
having received double-digit increases over the last three years. The highest paid last year was Dr William Moyes, executive chairman of Monitor. He earned £225,000 as a base salary and was awarded £10,000 as a performance related bonus in 2008/09. The total pay of chairs and chief executives of health-related quangos amounted to £5 million last year. This is excessive and should be trimmed back. The pay of quango chief executives should be no higher than that of the prime minister.

Strategic Health Authorities (SHAs) have no place in a decentralised NHS and should also be abolished. They operate secretly, doing the Secretary of State’s bidding in the regions. As more and more trusts become foundation trusts overseen by a dedicated regulator, Monitor, the purpose of the SHA diminishes further. The annual saving in administrative costs from the abolition of SHAs would be close to £130 million.

Since 1997, the number of administrative and clerical staff in the NHS has massively increased, and the proportion of total staff falling into this category has gone up by 15 per cent. The numbers working in ‘central functions’ (including personnel, finance, legal services and IT) has increased by over 50 per cent, while the number of managers in the NHS has grown from 22,693 to 39,913 – a 76 per cent increase. In any health system, good managers are essential but an increase of this size cannot be justified – it is a function of attempting to manage a highly bureaucratic system.

THE NATIONAL PROGRAMME FOR INFORMATION TECHNOLOGY

Another manifestation of this government’s impulse to centrally direct the NHS has been its attempt to impose a national IT system – the biggest health IT project ever attempted anywhere in the world.

---

14 Author’s calculation from SHA annual reports.
15 NHS Information Centre, NHS staff 1998-2008 (non-medical) data.
There is no doubt that IT plays a vital role in creating a modern, efficient healthcare system, helping with the monitoring of patients’ health and the management of those with chronic long-term conditions. Tele-medicine also has great potential to enable those with chronic conditions to remain in their own homes, supporting them in managing their own care. The evidence from the US Veterans Health Administration is compelling. They have managed to significantly reduce hospital admissions, in large part through the use of IT to better manage veterans with chronic conditions in the community.\footnote{J Brooks, ‘Veterans’ health system blazing trails’, 2008.}

The software system links 1,400 medical centres, community clinics and nursing homes. The system shows diagnoses, medications, scan and lab reports and provides prompts when vaccinations, chest x-rays, eye examinations and other preventative interventions are due. This is an intelligent use of IT which significantly improves patients’ quality of care and cuts costs for the health system.

Kaiser Permanente, a not-for-profit integrated managed care organisation based in California, has also developed an IT system which supports the care of patients. The early signs are that significant improvements in the care of those with chronic conditions have been achieved, resulting in better health and reduced hospital admissions.

Yet, in the UK, not only is the national IT programme running years behind schedule and billions of pounds over budget but it is failing to deliver the gains from IT seen elsewhere. The overall impression is of strategic confusion. At a time when the government was designing a reformed architecture for the NHS which was, in theory at least, more devolved, fragmented and market orientated, they introduced the national programme imposing IT solutions from above. This has not only been immensely costly but has caused enormous frustration among clinicians and local managers.

In a highly critical review of the national programme, Professor Wendy Currie of the Warwick Business School says that the National Programme for Information Technology (NPfIT) has
lacked three essential requirements for realising tangible benefits”: a convincing business case, stringent management approaches to implementation and evaluation, and proper risk assessment.\textsuperscript{18}

Problems seem to have been exacerbated by the awarding of contracts to only a very small number of large providers. This restriction of competition, of course, is likely to stifle innovation and increase costs. And with just two of the original four providers left following the departure of Fujitsu and Accenture, the NHS is in a highly vulnerable position.

The two elements of the National Programme which have faced the most trenchant criticism are the National Care Records Service (NCRS), which involves creating a national patient record database, and the Electronic Appointments Booking System, known as Choose and Book.

NCRS is likely to be completed some four years later than planned, has encountered enormous technical challenges, and has raised serious concerns about the confidentiality of patient records.\textsuperscript{19} Most fundamentally, the clinical and business case has still not been satisfactorily made for establishing a national database.


Meanwhile, the Choose and Book programme has caused enormous frustration for doctors and patients. It was originally designed as an electronic appointments booking system but was later converted into a central element of the Government’s commitment to offering patients a choice of hospital – in theory enabling the GP and patient to book an appointment on-line choosing from a list of hospitals. The introduction of this system fatally lacked clinical engagement and, like the NCRS, has been blighted by technical problems.

The early signs are that Choose and Book has been less effective at offering patient choice than the Government has claimed. Indeed, an early study of the system concluded that patients “did not experience the degree of choice that Choose and Book was designed to deliver”.\(^{20}\) If, for example, a particular hospital has long waiting lists it disappears from the list of choices available to the patient. Yet if patient choice is the goal, it seems bizarre not to offer patients the option of waiting a bit longer to see their preferred specialist or the one their GPs have recommended.

Even at this late stage, the government seems to have recognised the scale of the problem and has announced that the programme will be scaled back. The case seems to be based on the need to save unnecessary expenditure. Yet there is a risk that we could now have the worst of all worlds. A stalled national programme and no plan to develop the use of IT to improve patient care at the local level.

Three steps should be taken to address the NHS’s IT crisis:

First, the agency, Connecting for Health, which is responsible for the implementation of the National Programme for IT, should be abolished. Second, the Choose and Book system should revert back to what it was originally designed for – a simple on-line appointments booking system. This involves recognising that the software is insufficiently robust to achieve what is expected of it. This step would be widely welcomed by clinicians. And third, the National Care Records Service should

be abandoned. Clearly, contractual obligations with existing providers will have to be respected, but variations to contracts could be negotiated to achieve the desired objectives.

The strategy for the future should be based on local connectivity between primary and secondary health care and social care. A recent special report by The Economist highlighted the case for building from the bottom up, engaging with both clinicians and patients. This makes local managers and clinicians accountable for, and engaged in, the development of IT – a necessary requirement for any IT system to work effectively. This approach would also unleash the innovative energy of the small and medium sized IT companies which have been excluded from the development of the National Programme. There has been some recognition of the need for this in the confusingly named ‘National Local Ownership Programme’. And it would rebuild competition between providers – which is necessary to control cost in the long term. There should, in this process, be a focus on compatibility to allow for the transfer of data between systems.

We should also seek to put the patients in charge of their own health records where possible. At a minimum, patients should be given access to their records. The New York Presbyterian Hospital has launched a pilot electronic health records system that gives full control of data to individuals. Patients can decide which information they want to share with others.21

Another innovation, which could save valuable clinician and patient time, is to give the patient the right to communicate with their GP by email and telephone. In so many other walks of life we exchange emails to avoid waiting for a formal meeting. There is no reason why the same logic should not apply in the NHS. In March this year, Kaiser Permanente published evidence showing that by using email and telephone consultations they have cut GP visits per patient by an average of 26 per cent.22

---

2. A new approach to financing the NHS

A key challenge is to ensure that NHS funds flow in such a way as to maximise efficiency and the quality of patient care. This most emphatically is not happening at present. The system fails to channel funds into the prevention of ill health or the better care of those with chronic conditions. Consequently, it has proved ineffective at reducing the number of crisis admissions to hospital which are so disruptive to the patient and so costly to the NHS.

MAXIMISING EFFICIENCY THROUGH COMMISSIONING BY LOCAL HEALTH BOARDS

The Labour government’s reforms established a clear principle of separating commissioners of healthcare from providers. For this arrangement to work effectively there must be powerful commissioners which drive through improvements in quality and better value from providers. They should be seeking to manage demand and finding ways to get care closer to home. Yet, overall, PCTs have been weak in commissioning, allowing providers to prevail. They have tended to watch passively as cash has flowed into acute hospital trusts.

This means that local communities are not getting the best value for money. But local health boards with revenue raising powers and with more financial discretion could be much more effective.
The introduction of a new system of funding acute hospital trusts, with payments following the patient – known as Payment by Results (PBR) – gave hospitals a real incentive to increase activity. This helped to reduce waiting lists which had become a political priority.

Yet the system has had perverse consequences, as a simple increase in acute hospital activity diverts resources which could more profitably be directed towards the better management of those with chronic conditions or into the prevention of ill health. It is now imperative that PBR is reformed.

The tariff – the value of the PBR for each procedure – fixed nationally, is calculated on the basis of the average costs of procedures. It should instead be based on the cost of undertaking the procedure in the best run hospitals. This would provide an incentive to hospital trusts to adopt practices most likely to benefit patients and achieve efficiency gains. The NHS Institute for Innovation and Improvement estimates that there are currently up to £2.7 billion worth of savings that could be made if less efficient trusts met best practice.

Yet reform of the tariff should go further. There should be scope for the local commissioner to vary the tariff to secure the most efficient use of resources and an element of the payment should be specifically focused on quality. Where patient safety is seriously compromised, there should be no payment to the hospital trust. Finally, we should explore ways of incentivising hospital trusts to address the rise in emergency admissions by helping to improve community care. The recently published NHS Operating Framework does start to address issues relating to the tariff, but it should go further.

---


This approach could be implemented as follows:

1) Local flexibility to negotiate variations to the tariff with a proportion of the total payment being based on the hospital trust meeting specified quality standards. This could include measures of satisfaction from the patient.

2) If any one serious problem occurs with the patient’s treatment – so called ‘never events’ – then no payment would be made to the hospital. The list could include the following:
   - Hospital acquired infection
   - Deep vein thrombosis
   - Bed sores
   - Trips and falls
   - Medication errors – wrong drug or wrong dose
   - ‘Wrong site’ surgery

   This could prove to be an effective way of encouraging hospital trusts to focus more effectively on patient safety. Good news for the patient and good news for the finances of the NHS.

3) For emergency admissions, the full tariff should be paid up to the level of previous year’s level of admissions. Thereafter the tariff should be significantly reduced. This would provide an incentive to help develop community services, working together with primary care, to reduce crisis admissions. Again there should be local flexibility to vary this approach in order to avoid penalising a hospital in the event of a genuine emergency causing increased admissions.

To deliver improved efficiencies, acute hospital trusts need to continue the process of building financial responsibility amongst clinicians – devolving responsibility within the hospital and making clinicians accountable for their service line.

Local flexibility would also enable local health boards to recognise and respond to particular local needs. For example, in agreeing the tariff payment, account can be taken of the
fact that the cost of care in smaller hospitals serving rural communities may be higher.

AN ENTITLEMENT TO TREATMENT

Top-down targets have improved patients’ access to treatment. Nonetheless, there are perverse consequences to targets imposed from above. Ultimately, if the target is missed in any particular case, the patient has no right to treatment. Access targets should be replaced with an individual entitlement to treatment. If you don’t get treated on time, then the health board would pay for your treatment privately – if you so wished. The guaranteed access time should be condition specific rather than 18 weeks across the board, recognising that speedy access is more important with some conditions than others.

This entitlement acts as a guarantee that decentralised power will not compromise access to treatment, an approach which should apply to mental health as much as to other areas of healthcare. The application of this principle to mental health would have to be phased in as capacity was built up and as resources allowed. However, the economist Lord Layard has made the case powerfully that improving access to cognitive behaviour therapy pays dividends in reduced benefit claims as people are aided in their recovery and helped back to work.

This would give substantial new rights to those with mental health problems who at present do not benefit from the government’s 18 week waiting time target. In the worst cases, people in urgent need of therapy can be left waiting for months and sometimes over a year for access, despite the fact that clinical evidence shows that early intervention is critically important to improving the prognosis.

The government has announced something similar to this, but its proposed entitlement to access treatment will be a blanket 18 weeks and will perpetuate the discrimination against mental health service users by excluding them from the entitlement.

---

FINANCIAL LEVERS IN PRIMARY CARE

Despite its faults, Payment by Results does at least deliver greater transparency in the use of resources. However, PBR does not apply to primary and community services. No one has any real idea of how effectively or efficiently resources are used in these areas.

The case has been put by Chris Ham, professor of health policy and management at the University of Birmingham, that the government’s reforms have been far more relevant to elective surgery than to the operation of primary care and community health services and, in particular, the care of those with long term chronic conditions. Reforms have also failed adequately to address the importance of preventing ill health.\(^{26}\)

Another failing of the current operation of the NHS is that a greater divide has developed between primary and secondary care. GPs complain that the system does not facilitate close co-operative working for the benefit of patients.

The government’s approach to developing community services is centred on ‘practice based commissioning’ (PBC) – devolving the power of commissioning services to GP practices or groups of practices. This was intended to act as a catalyst for a transfer of services out of acute hospitals into local community settings. Progress, however, has been very limited. The government’s Primary Care Tsar, David Colin-Thome, has said of PBC: “I think the corpse is not for resuscitation.”\(^{27}\) The King’s Fund concluded that it: “Has to date proved a disappointment” and they highlight a structural flaw in PBC – the “fundamental conflict of interest between GPs as commissioners and as providers.”\(^{28}\)

Their report argues that: “This blurring of the purchaser/provider roles effectively limits contestability and potentially choice, but more importantly is compounded by the potential for personal gain arising from individual commissioning


\(^{28}\) King’s Fund, ‘Making it happen: next steps in NHS reform,’ 2008.
decisions. Declarations of interest to patients are a necessary but insufficient safeguard.”

So if PBC is failing to deliver care closer to home, and if the government’s reforms have failed to focus adequately on primary care, preventing ill health or on the better management of those with chronic conditions, what are the alternative solutions?

The non-profit making Kaiser Permanente system in California shows how a more integrated system can reap rewards. Kaiser was originally developed to keep workers healthier – thus keeping costs down – by treating their health problems before the onset of illness. All doctors throughout the system share a budget and responsibility for all care. Interestingly, in the Kaiser model, it is the clinicians that run the service. This is in marked contrast to the modern NHS where clinicians constantly complain of interference and imposed change from above.

Chris Ham has proposed a way of implementing some key Kaiser principles in the UK:

“Clinical integration would require practices to work closely with hospital based specialists in deciding how to use their resources, especially specialists who work in community settings. General practitioners and specialists would then jointly commission and provide services. As integrated groups evolve, specialists may move out of hospitals to become equity sharing partners in the multi-specialty practices.”

This could go hand in hand with introducing effective incentives for preventing ill health and managing those with chronic conditions better:

“By giving control over capitated budgets [a total sum of money for the care of each patient] to multi-specialty medical groups, they create strong incentives to keep patients healthy. ... Put another way, they help to promote the maintenance of health rather than the treatment of sickness.”

This, I believe, is the key to better outcomes and improved control over resources. The Local Health Board could

commission services of this sort. Patients could choose which multi-specialty group to register with.

Interestingly, the King’s Fund also suggests that instead of PBC, GP practices could be commissioned as ‘principal contractors’, bringing in other staff or organisations, including, when appropriate, voluntary sector groups or private companies to offer particular services.\(^{31}\) This could allow for the development of integrated health and social care groups. It would avoid conflicts of interest and would be transparent. Critically, it could offer real incentives for primary care to keep patients healthier and to manage chronic conditions better – with the potential for a more efficient use of resources and, more importantly, better outcomes for patients.

Despite the constraints of the current system, there are some exciting innovative developments taking place. Arrangements in Torbay, for example, provide some evidence of the potential benefits of integration – although without the use of capitated budgets.\(^{32}\) Torbay is one of three so-called Kaiser ‘Beacon’ sites within the NHS – effectively adopting the integrated care approach pioneered by Kaiser Permanente. Health and social care have been brought together in a ‘Care Trust’ – with social care staff being transferred to the NHS. They have established five integrated health and social care teams organised in localities and aligned to general practices. Each team has a single manager, one point of contact and one assessment process. Budgets are pooled.

In North East Lincolnshire, a ‘Care Trust Plus’ has been established. Social workers have had their employment transferred to the ‘Care Trust’ bringing together health and social care. Meanwhile public health professionals have transferred to the employment of the local authority so that they work alongside housing, regeneration, and children’s services. This is likely to enable the public health specialists to be far more effective in helping to shape local services.

---

Finally, the Improvement Foundation – a consultancy firm – has developed the ‘Unique Care Model’ of integrated care which has been applied with considerable success in various parts of the country. The approach is to work with whatever local structures are already in place, bringing together in partnership front line health and social care professionals, based on GP practice populations, focusing on the needs of the patient and their carers. The professionals involved measure their progress and are therefore able to demonstrate their success. Care workers are integrated into the team with nurses, working closely with GPs. This enhances professional pride; they wear a uniform as part of the care team; and they can train as health support workers, further developing their careers.

This approach appears to deliver significant reductions in unplanned hospital admissions. Where it has been developed, reductions in emergency admissions of between 13 and 25 per cent have been achieved. Reductions in bed days range from 20 per cent to 40 per cent. In Runcorn, the reported saving to the Primary Care Trust was approximately £1 million, with patients gaining immeasurably from the avoidance of hospital admissions and the loss of independence that goes with it.

These examples are, however, the exception rather than the rule. The approach described above would put primary care practitioners – working with specialists and care workers – in charge of the full budget for patient care. They would enter an agreement with the local health board committing them to meeting key objectives in terms of health outcomes for the patients they serve. This would provide the right incentive to improve health and well-being and better manage those with chronic conditions. This approach would also allow for slimming down of the bureaucracy within the local commissioning organisation. The commissioner would focus on monitoring the performance of these integrated care groups against the objectives set in the agreement.

There are various options about how to effect such a change from the current system. These are considered in a report [33] www.improvementfoundation.org/theme/long-term-conditions/unique-care-integrated-care-for-people-with-complex-nee-3
The NHS: a new liberal blueprint

published jointly by the Nuffield Trust and the NHS Alliance.\(^{34}\) Clearly, it would be important to pilot such an approach but in principle there is a powerful argument for moving to this model.

**PREVENTION IS BETTER THAN CURE**

The Wanless Report in 2002 argued that for the NHS to be financially sustainable in the long term, we had to achieve what the author described as the ‘fully engaged’ scenario.\(^{35}\) This requires high levels of public engagement in relation to their health.

In his review of progress in 2007, Derek Wanless concluded that we were some distance away from the fully engaged scenario. He criticised the low priority given to public health and highlighted the fall in the number of public health specialists at a time when other medical staff had increased by nearly 60 per cent.\(^{36}\)

When the NHS faced financial difficulties between 2005 and 2007 the Government cut public health budgets – a move which is entirely counter-productive in the long term.

At the same time, public health challenges have increased considerably. Governments across the developed world are faced with significant health problems associated with individual behaviour, such as smoking, drug-taking, alcohol consumption, poor diet and lack of exercise. These behaviours are linked to cancer, heart disease, stroke, kidney and liver disease. Perhaps the greatest threat comes from obesity. The trends are horrifying both for the health effects for individuals and for the potential cost to the NHS and the wider economy. It has been estimated that if current trends continue, the annual cost of obesity will be £45 billion by 2050.\(^{37}\) More recent analysis suggests that childhood obesity may have

---

levelled off. However, it is also clear that the impact will disproportionately affect poorer communities.

Views differ as to what role, if any, governments should have in trying to tackle these lifestyle conditions. On one side of the argument are those who think that any involvement smacks of the ‘nanny state’. People should be free to do exactly as they please, provided their behaviour doesn’t affect others. At the other extreme are those who believe it is government’s duty to save people from themselves; to intervene wherever possible to improve the health of the nation.

The judgement about the right of government to intervene is complicated by concerns over the financial sustainability of the NHS if nothing is done to influence behaviour. In a publicly funded health system, government – and the tax-payer – clearly has an interest. It is also surely a legitimate role for government to ensure that people are able to make informed decisions about their health and to encourage, but not force, people to do things which will help keep them healthy. Furthermore, it must be a central interest of government to address the acute and shocking inequalities of health in England.

So far the government’s approach seems to be largely based on exhortation. Asserting, for example, that obesity is now a top priority does not make anything happen.

So, if government is to influence behaviour, what works? The academic Julian Le Grand has produced a study of the role of economic incentives on professionals, commissioners and individuals. This is a critical issue: current strategies are manifestly not working and experience from elsewhere tells us that incentives can have an effect on behaviour.

The government has, so far, focused on providing incentives for professionals to deal with these problems. GPs are encouraged to pursue a number of key priorities by way of


the Quality and Outcomes Framework (QOF) – a pay incentive scheme – which has had some success.\textsuperscript{41} However, QOF, as currently constructed, has failed to make any real impact on some key public health challenges. One of the targets relates to smoking. But payment under the scheme does not depend on demonstrating success in cutting smoking rates among patients. Likewise, on obesity, the QOF system incentivises GPs to weigh their patients and keep a register but does nothing to link payments to success in helping patients to lose weight.\textsuperscript{42}

The government is now seeking to overhaul the system. The Department of Health has made it clear that it wants a greater focus on outcomes rather than process.\textsuperscript{43} The Health Select Committee has also helpfully argued that tackling health inequalities should be ‘an explicit objective’ during the annual negotiations on QOF.\textsuperscript{44} The basis of reward should, for example, recognise the more entrenched health challenges in disadvantaged communities and tie payments to achieving success in combating those problems.

Reforming the system, particularly to link payments to outcomes, should happen without delay. The British Medical Association seems willing to engage so an agreement should be achievable.

Incentives should not be limited to professionals; the role of commissioners is also vital. At present, as previously discussed, whenever a Primary Care Trust is under financial pressure, public health is one of the first areas to be cut back. Liberal Democrat proposals for democratically elected health boards with the power to raise a proportion of their revenue locally would give a very clear incentive to find ways of reducing the burden of ill health locally in the longer term. Having responsibility for a proportion of revenue raised

\textsuperscript{42} S Tanday, ‘Has QOF proved to be a success?’, GP newspaper, 2008.
\textsuperscript{44} House of Commons Health Committee, ‘Health inequalities’, 2009.
would establish a direct financial interest in finding strategies which improve health and well-being. But this is unlikely to be sufficient. Le Grand looks at possible reform to the way in which funds are distributed from central government. One option, which he assesses positively, is for the introduction of matching grants – for example offering to match every £1 spent on preventive programmes with £1 from the centre. Le Grand concludes that this approach “would reduce the costs of these programmes relative to other demands on PCT resources and thus encourage spending on them”. The matching grants could be targeted on specific programmes that would benefit less well off groups where some of the most challenging health problems are concentrated.45

Local health boards could invest in a range of prevention strategies – working alongside local authorities and employers. One example of action which could be taken is on cycling. The organisation, Cycling England, commissioned a study to demonstrate the economic benefits – including savings for the NHS which the promotion of cycling can deliver. The analysis estimates that a 20 per cent increase in cycling would deliver a total saving of £523 million. The analysis did not include the impact of reduced obesity and improved children’s health.46

The government’s approach has been to select a small number of ‘cycling towns’ and inject funds into those areas. They have also provided encouragement through planning guidance. But this approach will only ever scratch the surface. Incentives to commissioners working with local authorities to develop preventive health strategies might be the way to get things moving across the country. Work with employers is also important. Enlightened employers have demonstrated significant improvements in the health of the workforce achieving reduced absenteeism by focusing on health and well-being. The food company, Ginsters, for example, working with the local authority, have established a 24 hour gym, invested in cycle paths and walkways and do health promotion work with workers and their families. Their absence rate is 3.1 per

cent compared to an average for manufacturing of 7.8 per cent.47

Finally, we need to explore what scope there is for creating incentives for individuals to live healthy and active lives. Here, insurance schemes may have something to teach us. The behavioural problem we have to grapple with is that the pleasure gained from activities which may be damaging to your health are immediate whereas the damage to your health is generally many years in the future – and the negative impact is often uncertain. So the teenager who gets completely drunk on a night out with friends discounts the risks of liver disease or alcoholism many years later if they are even aware of those risks. The same goes for someone who takes up smoking or binges on fast food. The challenge may be to bring forward the potential advantages of healthy living with a range of incentives.

Tom Lerche, Health Care Practice Leader at AON Consulting, looked at the evidence of the impact of ‘consumer-directed health’ (CDH) plans – policies which encourage the individual to take steps to maintain or secure good health – and the evidence appears to be very positive.

The concept was first pioneered in South Africa by Discovery, a life and health insurer. They have offered CDH programmes for the last 16 years, which were subsequently introduced into the US in 2000-2001. Now the insurance company, PruHealth, offers a similar policy in the UK.

The idea is that an individual policy holder is encouraged to take steps to maintain their health. This could include participating in screening programmes, having health risk assessments, disease management and taking exercise. Those who participate can earn points which can qualify the individual for benefits such as cheaper travel vouchers, health club discounts or movie tickets.

There is clear evidence of positive impact. The insurance company sees reduced claims from those who participate in

47 www.bitc.org.uk/resources/case_studies/afe_2138.html
these programmes. Individuals benefit from improved health. There is no compulsion, just encouragement. Evidence also shows that it can work for those who already have chronic conditions. Lerche’s report found that:

“Members with chronic disease are eligible for incentives based on completion of disease management and cash-based recognition for participation in risk-reducing programmes such as smoking cessation, weight-loss and exercise. Not only do these incentives result in more cash-in-pocket to fund medical care for chronic disease but it also has a direct impact on the health cost of members.”

The question, then, is whether there are any lessons for a tax funded system such as the NHS. As noted, health boards, raising a proportion of their funding locally, would have a direct interest in keeping costs under control – just like insurance companies. They should be free to experiment with incentive schemes, focusing efforts particularly at those communities which are hardest to reach and at disease groups such as those with diabetes, where the potential benefits to the individuals are considerable and where there are real gains to be achieved in terms of reducing cost. Direct payments of cash should, however, be avoided.

This is not a panacea but the evidence suggests that such schemes could play a part in a wider strategy to redirect resources and focus towards health and well-being and away from the concept of the NHS as primarily a sickness service.

**COMPETITIVE LOCALISM – DRIVING UP STANDARDS AND ACHIEVING BETTER VALUE**

In any discussion about decentralising control in the NHS, the accusation can be made that you will inevitably end up with a ‘postcode lottery’. Yet, despite our highly centralised system, we hear constant complaints that a postcode lottery already exists. What is worse is that there is no accountability for...
variations in access or quality of service. Local commissioners are not accountable to the communities they serve.

In a reformed NHS, with local commissioners democratically accountable and with local people armed with information about quality of care and value for money, there are additional drivers for improved performance. We could challenge our local health board and compare their performance with other areas, developing a dynamic that I call ‘competitive localism’.

One recent move by the Department of Health could help in this regard. A web based system called ‘programme budgeting’ allows you to compare the amount spent per specialty in each area and also the outcomes achieved for that expenditure. The system is still in its infancy but it provides additional evidence of the most effective application of resources. This is an essential tool for local commissioners to use in improving the use of resources – and for local people in holding their health board to account. Benchmarking information can also help in making judgments about performance.

Well informed patients would demand of their local health board that effective treatments should be made available locally. Democratic accountability should be better at driving change than the current top down bureaucratic approach. Take, for example, photodynamic therapy (PDT). This treatment, pioneered at University College London Hospital in London, has the potential to offer an alternative to surgery, chemotherapy and radiotherapy for the treatment of a range of cancers. It is non-invasive and has much less of an impact on the patient’s well-being. Patients are often able to return home within as little as three days following treatment. The cost of PDT is dramatically less than alternative treatments. It has been estimated that there is a potential saving of up to £2 billion if the full potential of PDT could be realised. Yet, for those cancers where NICE has approved this treatment, take up across the NHS is very low. Local health boards must be alert to new developments which can have potentially massive benefits for patients and reduce costs to the NHS.
3. Returning autonomy to NHS staff

A remarkable feature of this government’s tenure is that despite increasing investment by 50 per cent in real terms, including substantially raising earnings, over the last seven years they have spectacularly lost the confidence of the medical profession. This has been demonstrated in opinion polls and in other surveys of health professionals. Any discussion with GPs or dentists almost inevitably involves trenchant criticism of the government’s stewardship of the NHS.

The extent to which reform has been imposed from on high causes the most frustration. The list of complaints is endless: organisational change, contractual changes forced through with little consultation, a disastrous new online recruitment system for junior doctors introduced without piloting, the failed National Programme for IT imposed from the centre, a completely new system of financing NHS dental treatment introduced without agreement and without testing.

This drives professionals crazy. It removes the sense of professional autonomy and accountability. It breeds a dependency culture. Both local managers and clinicians get used to instruction from Whitehall. The Healthcare Commission report into the high death rates at the Mid-Staffordshire NHS Foundation Trust revealed a culture of bullying in the enforcement of targets. The government sought to dismiss this as failed local management but you hear similar stories

time and again in hospitals around the country. Clinicians also feel that their capacity to innovate and experiment is often constrained.

The NHS is a remarkable institution. Those who work in it have chosen a career caring for others. There is still an extraordinary commitment to the ideals of the NHS. Yet the patience of so many people within the NHS is being tested to the limit.

We all know that to get the most out of people we have to empower them – giving them a real say, an involvement in their workplace. In the context of the NHS this includes not just GPs, hospital doctors, consultants and dentists but all staff – nurses, therapists, other health workers, support workers, care staff and administrative staff.

Engaging staff is equally important in ensuring effective reform. The philosophy of organisations such as John Lewis is instructive. Principles such as involving all staff in decision making (rather than imposing change) and enabling staff to share in the success of the organisation can be applied in health and social care.

A recent report commissioned by the Employee Ownership Association demonstrated the potential benefits of co-ownership in public services. The author of the report, Charles Leadbeater, summed it up in this way:

“Staff in co-owned public service organisations frequently say they are willing to ‘go the extra mile’ to deliver a better service for people. The public sector will need more of that spirit. That is why promoting greater co-ownership should be a strategic priority for the next phase of public service renewal.”

One example of such a business operating within the NHS is Central Surrey Health. This is a not-for-profit, social enterprise owned by all its 780 employees. It was established following a review by the local Primary Care Trust of its community based services. The social enterprise, made up of nursing and

51 C Leadbeater, ‘Innovation included: why co-owned businesses are good for public services’, Employee Ownership Association, 2008
therapy teams, runs a range of health services. The potential value of this sort of organisation is that it combines a public service ethos with a capacity to be more responsive, more fleet of foot, than the traditional public sector. Tricia McGregor, the joint managing director of Central Surrey Health says:

“We combine the values and principles of the NHS with the can-do culture of a successfully-run business. This means the people who are most in touch with patients’ needs, our nurses and therapists, are now in charge of providing the services.”

The organisation’s approach recognises the challenge of providing better care while ensuring that the NHS remains financially sustainable. It is keen to develop partnerships with others with a view to reducing reliance on hospitals and doctors, ‘combining fitness, diet, leisure and health.’

Another social co-owned business operating in this sector is Sunderland Home Care Associates. It is owned by more than 200 staff who provide over 4,000 hours of social care every week. It has won awards for its innovation as a social enterprise. The Commission for Social Care Inspection has recognised the quality of the care it provides.

There is a need for research into the potential benefits of employee ownership in public service provision in health and social care. But real opportunities exist to develop this sector as Primary Care Trusts have been required to divest themselves of community services focusing exclusively on commissioning. Leadbeater argues for the development of ‘easy to use organisational models’ to enable the establishment of co-owned organisations.

Frustratingly, despite the government promoting the model, new social enterprises are only emerging at a trickle. One of the key problems remains the pension entitlement of staff. Although the government claims to have resolved the issue by confirming that staff transferring will retain their NHS pension rights, impediments remain. The Department of Health wants any new initiative of this sort to be based on a contract with the local PCT which guarantees pension rights for transferring
staff but not for any staff subsequently taken on. Those thinking of establishing social enterprises are put off by this because they know that they will be competing for staff with NHS organisations which offer superior pension rights. This potentially puts them at a disadvantage. To kick-start a real shift towards this sort of enterprise, a change of approach is needed.

The John Lewis model could also be transformative in the operation of hospitals. We should introduce a mechanism to allow staff to vote for their hospital trust to become a wholly owned employee trust. This style of ownership is already emerging in the private sector. Take, for example, Circle, which among other facilities runs the independent sector treatment centre at Burton on Trent. Half (49.9 per cent) of Circle is owned by Circle Partnership Ltd, which belongs to everyone who works in clinical services, directly or indirectly and at every level.

Healthcare should be run from the bottom up with ownership and the decision-making process lying with the professionals who are closest to the patients. As Professor Jonathan Michie, President of Kellogg College at Oxford University puts it: “Companies with employee ownership as part of their business model often demonstrate higher productivity, greater innovation, increased customer loyalty and enhanced talent recruitment and retention.” These are features we badly need in the NHS.

Finally, we must also build on the invaluable contribution which the voluntary sector can make. There are so many voluntary organisations working within health and social care where the quality of care and the commitment offered by both staff and volunteers is remarkable and where their success rate is very high.

Cruse Bereavement Care, run on a shoe-string, gets many people’s lives back on track following bereavement using dedicated volunteer counsellors. Volunteers often have

personal experience of bereavement challenges and so want to make a difference to others. Local groups working in the field of mental health offering befriending services, companionship, sporting activities and so on make a real difference to people’s lives. Northamptonshire Carers is one of many remarkable third sector organisations providing assistance to carers. Working alongside Social Services, they provide invaluable support, helping to avoid the crises which so often end up with hospital admissions. These organisations are incredibly cost effective.

Yet too often these organisations suffer cutbacks in funding when budgets are tight. Their role should be enhanced and nurtured. In the USA, the recession is resulting in a renewed interest in volunteering, particularly among young people who may be taking longer to find paid employment. We should look at the potential to develop the volunteer workforce in health and social care.
4. Patients with rights and responsibilities

A key objective of a liberal health system must be to ensure that patients are given a real say in their treatment. Patients need to be able to decide where and when they are treated but also have the tools to ‘self care’ more effectively.

Many patients would probably say that they were more interested in which specialist they are referred to, rather than which hospital. In most cases, we need advice from our GP about the best referral but there should also be access to independent advice and advocacy – particularly for those who may not be good at fighting their corner.

Access to relevant information is certainly important in helping an individual make the best choice – and the more information available about performance and levels of patient satisfaction in both primary and secondary care the more this is also likely to drive up standards. No professional wants their service compared unfavourably with others.

We are now seeing the emergence of websites such as iwantgreatcare.org where patients can post their own experiences of the care they have had. This approach is well established in the travel and hotel sectors. This is a positive development.

SELF-DIRECTED CARE

It is worth noting that the greatest innovation in service delivery in health and social care has actually been developed by local authorities rather than central government.
The idea of giving the budget to the individual service user so that they can decide what their priorities are, rather than a bureaucracy deciding for them, originated as a result of pressure from disabled people. Local authorities have developed this very different approach to the care of those in need of support. It has the potential to deliver more personal care at a lower cost. In essence, it puts an individual with very limited resources into the same position as someone with their own money – making their own decisions about their care – but crucially with support, if they want it, in making the best decisions.

To start with, experiments were developed giving ‘direct payments’ to individuals so that, for instance, a husband with dementia and his wife could chose their own carer and employ them directly. It helps ensure available funds are used to best effect. Those who have experienced ‘direct payments’ often talk of how their experience of care has been transformed. Instead of waiting interminably for a care worker to be sent by the local authority or some contracted-out agency they can make their own arrangement with their employee about when they want them to arrive and what they want them to do. This is likely to result in more settled care arrangements.

This is not a panacea. Many elderly people do not want the responsibility of employing someone directly. We also have to recognise the potential vulnerability of the employee in these circumstances. However, on the other side of the coin, direct employment can often lead to a more fulfilling role for the worker, and safeguards can be developed in terms of support and training arrangements.

A further recent development has been the trials of individual budgets where the service user is given a budget for the year and is able, with support, to determine how that budget will be spent. The service user does not have the responsibility of directly handling the money but is given power over how it is spent.

The early evidence suggests that the use of direct payments and individual budgets has had impressive results.\(^5\) \(^3\) Charles Leadbeater, ‘Making it personal’, Demos, 2008.
Leadbeater points to higher levels of satisfaction from service users, better health and well-being, more engagement from some ethnic minority groups which have been reluctant to engage in more traditionally provided services and, critically, better use of resources. Leadbeater found that for the most expensive services, such as packages for adults with learning and physical disabilities, the savings can be as high as 45 per cent. ¹⁵⁴ This means that the available funds can go further providing help for more people. It could also lead to a far more fulfilling role for the professional social worker, who shifts to becoming more of an adviser or partner in developing the best care arrangements. It is essential that the service user is not left on their own. Guidance and support in making the best decisions with an individual budget is of fundamental importance.

Now the debate must turn to how far this approach can be deployed within the NHS. Clearly, there are limitations but the potential is considerable and the case for developing these enabling, empowering concepts, is overwhelming – particularly where we see traditional service delivery models failing to work effectively.

The government, to its credit, has at last accepted the principle of self-directed care within the NHS. Until recently, the barrier was absolute. For example, a family who had two boys in their twenties with severe disabilities benefited from direct payments from the local authority to fund their sons’ care package. ¹⁵⁵ It worked particularly well with an established team of support workers. Then their condition deteriorated resulting in them becoming entitled to free NHS continuing care. They were told that they would lose their direct payment and their dedicated team and would instead get whatever care the NHS was able to offer. This demonstrates graphically how a bureaucratic system can fail to provide the personal care and support individuals need.

So far, the government has sanctioned a number of pilots of personal health budgets covering a range of patient groups.

⁵⁵  Author’s parliamentary casework.
These pilots will run for three years. There is real scope for such an approach for mental health service users – where a greater say and more control over care choices can be of enormous value in terms of aiding recovery – and with those with learning disabilities.

Another possible area where personal budgets could be employed is in maternity services. We hear endless stories of a service under intense strain. We read of midwives being trained but then unable to get employment. A parliamentary answer confirms that the workload of individual midwives is greater now than at any time since 1997.\(^{56}\) The UK also has one of the lowest rates of home births in Europe. In the Netherlands approximately 30 per cent of women give birth at home compared to around 2.7 per cent in the UK.\(^{57}\) At the same time, the country has one of the highest rates of expensive caesarean sections, now at 25 per cent.\(^{58}\) Given that the WHO advises that medical reasons can justify a rate of caesarean sections of up to 15 per cent, it seems as if many women are having caesareans without good medical reason.

This is not to argue that home birth is the right choice. But women should be given an informed choice. Evidence suggests that where a woman has confidence in her own midwife, she is more likely to have confidence in opting for a home birth.

The only existing pilot using personal budgets for maternity services, in Eastern and Coastal Kent, will hopefully provide evidence of the impact of giving more control to the woman in terms of choosing which sort of service to access.

This concept turns the traditional model of public services on its head. But it could be transformational, delivering better health and well-being, greater engagement in public services, closing the inequality gap between those who have choice because they can afford to buy the right services with their own money and those who have had to rely on sometimes

\(^{56}\) A Keen, ‘Midwives manpower’, House of Commons, Written answers and statements, 15 October 2009.


\(^{58}\) The NHS Information Centre, ‘No change in caesarean rate but wide variation between trusts’, 2009.
poorly performing public services. It could also lead to the same efficiency savings as have been achieved in social care.

**PATIENTS’ RESPONSIBILITIES IN A PUBLICLY FUNDED NHS**

The government’s NHS Constitution recognises that patients have responsibilities as well as rights. However, the concept remains very vague.

The benefits of this country’s system of funding are considerable and the Liberal Democrats have always been and will continue to be strong supporters of the NHS, funded by progressive taxation. But we should recognise that there is a risk that we take free care for granted and fail to appreciate the costs of irresponsible behaviour. As a liberal, I strongly believe that with freedom comes responsibility. There are consequences to our actions.

As we face the growing challenge of sustaining the NHS in much tougher financial circumstances, we should surely look to see where encouraging greater responsibility might help save costs resulting in more money being available for patient care.

One example could be how we deal with the problem of the impact of alcohol abuse in Accident and Emergency Departments. We have a serious problem with people turning up at A and E in an inebriated state and then causing disruption to staff and other patients.

In every A and E department there should be procedures in place to refer anyone who attends, where there is evidence of an alcohol problem, to alcohol treatment services. Evidence suggests that this approach reduces repeat visits and clearly potentially helps the individual.\(^{59}\) But where someone has gratuitously got themselves very drunk and where they then threaten or abuse staff, surely there should be consequences? Is there a case for sending a bill to that individual following their treatment? In any event, it may also be worth informing

---

that individual of the total cost of their treatment following their visit to A and E. An alternative approach could be to build closer links with the police so that cases of threatening or abusive behaviour at A and E do not go unpunished. A pilot at Bolton Hospital involved the police giving fixed penalty notices to those in A and E who behave in a threatening or aggressive manner.

Another option would be for A and E departments to work together with local licensed premises to ensure that anyone who behaves in a threatening or aggressive way to staff in A and E should then be barred from local pubs and clubs for a period of time. This approach has been pioneered at the Queen Elizabeth Hospital in Kings Lynn. Patients who behave in this way can end up with a ban under the local Pubwatch scheme. It could be made a licence condition that late night clubs and pubs participate in such arrangements.

There is an argument that any approach of this sort creates the thin end of the wedge, breaking the principle of free care. However, there is such a clear and serious problem with the impact of alcohol abuse, its effect on A and E staff and the cost to the NHS that it is legitimate to explore such schemes. Why do we justify charging those on low incomes a proportion of their NHS dental costs or requiring a payment for a prescription, and yet protect those whose irresponsible behaviour cost the NHS dear and put staff at risk?

The final example relates to the cost of medicine. The NHS protects individuals from knowing the cost of any treatment they receive. It is clearly important that someone who needs treatment should not be left feeling guilty because the particular treatment might cost a substantial sum. Yet we are also aware that often expensive prescription drugs are left unused. The trialing of a drug pricing scheme would provide an opportunity to assess whether people’s behaviour changes in a positive way.
Conclusion: the NHS after the age of austerity

There is no doubt that substantial efficiency improvements can be secured within the NHS. So much evidence is already available which, if deployed, could lead to real improvements.

The risks of not acting, and of trying to maintain the existing bureaucratic system in ever tighter financial circumstances, are manifest. Rising costs, with no real terms increases in funding, will result in an intensifying financial crisis. Indiscriminate cuts will undermine support for the NHS.

Alternatively, we have the potential for reform to deliver better care, with greater focus on preventing ill health, and more effective management of those with chronic conditions. We can create an NHS which is more responsive and which is accountable to the communities it serves. In so doing, it will be possible to rebuild the remarkable spirit which drives those who work in the NHS, liberating staff from the deadening burden of political direction from Whitehall.

Furthermore, we can make better use of the resources available to ensure that the NHS can be sustainable in the 21st century, reducing the over-bloated central bureaucracy and ensuring that we use money effectively to achieve our shared objectives.

This will require political will, but the prize is so precious that we must not fail.